UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS SAN ANGELO DIVISION

TORIBIO MUNGUIA and	§	
KATHY MUNGUIA	§	
	§	
v.	§	**Civil Action No. 6:09 CV-00023-C**
	§	
	§	
	§	
AUTOZONE TEXAS, L.P.	§	
AUTOZONE, INC., and	§	
AUTOZONERS, LLC	§	

APPENDIX TO MOTION TO COMPEL ARBITRATION

PART 2
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(2) the Injury is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of such treatment;

(3) the Injury was caused by the Participant's willful intention and attempt to injure himself or herself or to injure another person;

(4) the Injury occurred while the Participant was employed in violation of any law;

(5) the Participant's horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;

(6) the Participant's cell phone use, or second-hand smoke was a proximate cause of the Injury;

(7) the Injury was incurred while the Participant was "on suspension," "laid off" by his or her Employer, on leave of absence for any other reason, or otherwise outside of the Course and Scope of Employment;

(8) the Injury arose out of an act of a third person intended to injure the Participant because of any reason other than one directed at the Participant as an Employee of, or because of his or her employment by, an Employer;

(9) the Injury arose out of voluntary participation in an off-duty recreational, social or athletic activity not constituting part of the Participant's work-related duties, except where these activities are expressly required in writing by an Employer (more than an invitation or request to participate or attend);

(10) the Injury arose out of an act of God, unless the Participant's employment by an Employer exposes such Participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;

(11) the alleged Injury is feigned or an attempt to defraud the Employer;

(12) the Injury arose out of the Participant's participation in:

(A) a riot or act of civil disturbance;

(B) a war, declared or undeclared;
(C) any act of war or terrorism;

(D) a felony or an assault, except an assault committed in defense of an Employer's business or property; or

(E) service in the military of any country or any civilian non-combatant unit serving with such forces;

(13) any damage or harm arising out of the use of or caused by –

(A) asbestos, asbestos fibers or asbestos products; or

(B) the hazardous properties of nuclear material or biological contaminants;

(14) the Injury arose out of the injured Participant's participation in the commission, or attempted commission, of any crime;

(15) the Injury occurred while the Participant was traveling or flying in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation if the Participant is:

(A) flying in any aircraft that is rocket propelled;

(B) flying in any aircraft that is used for aerobatics, racing or an endurance test, crop dusting, seeding, fertilizing or spraying, fighting a fire, any exploration or pipe or power line patrol, the pursuit of animals or birds, aerial photography, banner towing or skywriting or any test or experimental usage;

(C) flying when a special permit or waiver from the proper authority has to be issued;

(D) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

(E) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

(F) riding as a passenger in an aircraft owned, leased, or operated by the Company;

(16) the Injury did not occur during the Participant's Course and Scope of Employment; or

(17) the Injury was not timely reported (or requested information was not timely provided) in accordance with the timeframes specified under Article IV herein.

1.27 "Maximum Benefit Limit" means the total amount of all benefits payable to, or with respect to, any Participant under the Plan with respect to an Injury. Payments made for each form of benefit shall be counted towards the Maximum Benefit Limit

amount. The Maximum Benefit Limit for this Plan is $200,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all Participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, shall not exceed $500,000. Such aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each Participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

1.28 "Medical Benefits" means any benefit payable under Section 3.4.

1.29 "Medically Necessary" means the services, procedures or supplies, which are:

(a) required, recognized, and professionally accepted nationally by physicians as the usual, customary and effective means of diagnosing or treating the condition;

(b) the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the Participant; and

(c) not primarily for the convenience of a Participant, the Participant's family, a physician, or a facility.

Even though a physician may have prescribed a particular treatment, such treatment may not be considered Medically Necessary within this definition or may otherwise be excluded from coverage under the terms of this Plan.

1.30 "Medical Rehabilitation Hospital" means an Approved Facility that:

(a) is licensed;

(b) provides facilities for the diagnosis and inpatient rehabilitative treatment of disease or injury with the objective of restoring physical function to the fullest extent possible. Examples of conditions treated in a rehabilitation hospital are: amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, cerebrovascular accident, paralysis;

(c) has facilities or a contractual agreement with another hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement;

(d) provides all normal infirmary level medical services required for the treatment of any disease or injury occurring during confinement;

(e) has a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, one of whom is present at all times during the treatment day;

(f) is accredited as a medical inpatient rehabilitation hospital by the Joint Commission on Accreditation of Rehabilitation Facilities;

(g) is not a place for rest, the aged, drug addicts or alcoholics, a chronic disease facility, a nursing home or sheltered workshop; and

(h) does not provide as its primary purpose custodial care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services. Any identifiable charges for educational, vocational or social adjustment services are not covered under the Plan, unless otherwise provided as a Covered Charge.

1.31 "Medicare" means Title XVIII of the Social Security Act, as amended, and the regulations promulgated thereunder.

1.32 "Modified Duty" means work which is either --

(a) a temporary accommodation that allows an Employee to perform his or her regular job; or

(b) an alternate, temporary job that complies with the Employee's work restrictions and Employer needs.

1.33 "Occupational Disease" means a condition marked by a pronounced deviation from the normal healthy state of a Participant arising out of such Participant's assigned duties in his or her Course and Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of a Participant's assigned duties in his or her Course and Scope of Employment. Any provision of this Plan to the contrary notwithstanding, if an Employer has purchased an insurance policy described in Section 5.2, the purpose of which (in whole or in part) is to pay Plan benefits to Participants or indemnify the Employer for Plan benefits, then the Participant's last day of last exposure to the condition causing or aggravating such Occupational Disease must have taken place during the policy period.

1.34 "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in the Participant being -

(a) unable to fully perform the normal duties for which he or she was employed;

(b) under the regular care of an Approved Physician;

(c) released to Modified Duty by such Approved Physician; and

(d) working for the Employer in such a Modified Duty position approved by the Employer.

1.35 **"Participant"** means a Covered Employee who satisfies the eligibility requirements of Article II.

1.36 **"Plan"** means the AZTEX Advantage: AutoZone Texas Occupational Injury Benefit Plan as herein set forth and as it may from time to time be amended.

1.37 **"Plan Administrator"** means the Company.

1.38 **"Plan Year"** means a 12 calendar month period beginning each January 1 and ending the following December 31; provided, however, that the initial Plan Year shall be the period beginning August 1, 2005 and ending December 31, 2005.

1.39 **"Post-Service Claim"** means any claim for a Medical Benefit that is not a Pre-Service Claim.

1.40 **"Preexisting Condition"** means any Participant illness, injury, disease, or other physical or mental condition, whether or not work-related, which originated or existed within the 6 month period prior to the date of Injury.

1.41 **"Pre-Injury Pay"** means --

(a) for salaried Participants, regular bi-weekly salary from an Employer at the time of the Injury;

(b) for hourly Participants, the average earnings from an Employer for the 13 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a Participant has worked for an Employer for at least one but fewer than 13 weeks immediately preceding the date of Injury, a weekly average will be based upon the earnings received over his or her period of employment; provided, further, that if such a Participant has been employed for less than one week, or if his or her earnings as of such date have not been fixed or cannot be reasonably determined (in the judgment of the Claims Administrator), such 13-week average will be based upon the earnings received over such period by a similar employee of the Employer.

"Pre-Injury Pay" shall include pay for overtime and Participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" shall not include any bonuses, benefits (including, but not limited to, Employer contributions to any employee benefit plans or matching contributions to a retirement plan) or other extraordinary remuneration.

1.42 **"Pre-Service Claim"** means any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care.

1.43 **"Relevant"** shall mean, with respect to the relation of a document, record or other information to a claimant's claim, that such document, record or other information:

(a) was relied upon in making a benefit determination on the claimant's claim;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the actual benefit determination;

(c) demonstrates compliance with the Plan's administrative processes and safeguards required for making the benefit determination; or

(d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The individual records or information specific to the resolution of one claimant's claim shall not be considered relevant to another claimant's claim.

1.44 "Skilled Nursing Care" means service provided in a Skilled Nursing Facility by a R.N., L.P.N., or licensed vocational nurse (L.V.N.), provided that the care is Medically Necessary and that the treating Approved Physician has prescribed such care. However, no benefit will be payable under the Plan for the following expenses:

(a) charges for food, housing, or homemaker's services;

(b) charges for the services of a person licensed or unlicensed who ordinarily resides in the Participant's home or is a member of the family of either the Participant or the Participant's spouse;

(c) charges for an illness or injury unrelated to the original hospital confinement; or

(d) charges that do not follow a hospital stay or are incurred when the Participant could otherwise receive services from private duty nursing at home.

1.45 "Skilled Nursing Facility" means a section, ward, or wing of a hospital, or a free-standing healthcare facility, which:

(a) provides room and board;

(b) provides nursing care by or under the supervision of a nurse;

(c) provides physical, occupational, and speech therapy furnished by the facility or by others under arrangements made by the facility;

(d) provides medical social services;

(e) provides drugs, biologicals, supplies, appliances and equipment ordinarily furnished for use in such a facility;

(f) provides medical services by staff Approved Physicians;

(g) has an agreement with a hospital for diagnostic and therapeutic services, the transfer of patients, and exchange of clinical records;

(h) provides other services necessary to the health and care of patients that are generally provided by such facilities; and

(i) is licensed or registered in accordance with local and state laws and regulations.

1.46 "Total Disability" and "Totally Disabled" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which causes the Participant to be-

(a) unable to perform the normal duties for which he or she was employed;

(b) under the regular care of an Approved Physician; and

(c) unable to engage in Modified Duty or any other occupation for wage or profit.

1.47 "Traumatic Event" means any act involving, or of the nature of, a violent crime or any other incident that would result in severe shock to a reasonable person.

1.48 "Urgent Care Claim" shall mean any claim for medical care or treatment with respect to which application of the time periods for making non-urgent Pre-Service Claim Determinations (i.e., generally, 15 days after the Claims Administrator's receipt of the claim):

(a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim within the meaning of subsection (a) above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, such claim shall be treated as an Urgent Care Claim for purposes of this Plan. **The characterization of a claim as an Urgent Care Claim**

solely impacts the timeframes and other procedures for claims processing under ARTICLE VI, and in no way changes this Plan's approved medical provider, pre-authorization, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Covered Charge unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Physician or Approved Facility, and (2) all determinations relating to the physical condition of a Participant, upon which the payment of benefits is based, must be made by an Approved Physician. Urgent Care Claims may not arise to the level of involving Emergency Care. A Participant's decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. The determination of whether a claim involves Emergency Care shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Appeals Committee deems appropriate.

1.49 "Usual and Customary" means a charge that is not more than the amount charged when there is no insurance, and is not more than the prevailing charge in the locality for a like service or supply. A like service is one of the same in nature and duration, requiring the same skill and performed by one of similar training and experience. A like supply is one which is the same or substantially equivalent. Locality is the city or town where the service or supply is obtained, if it is large enough so that a representative cross-section of like services or supplies can be obtained. In large cities, it may be a section or sections of the city, if the above criteria can be met. In smaller urban or rural areas, locality may have to be expanded to include surrounding areas to arrive at a representative cross-section.

1.50 "Wage Replacement Benefits" means any benefit payable under Section 3.1.

ARTICLE II

ELIGIBILITY, NATURE OF PAYMENTS AND ARBITRATION OF INJURY-RELATED DISPUTES

2.1 Eligibility. Each Covered Employee shall become a Participant in this Plan as of the later of (A) 12:01 a.m., August 1, 2005, or (B) the time and date of his or her employment as a Covered Employee. Except to the limited extent provided under Article III regarding the continuation of certain benefit payments, if a Participant ceases to be a Covered Employee, he or she shall thereupon cease to participate in this Plan; provided, however, that if such Participant is thereafter reemployed as a Covered Employee, he or she shall resume participating in the Plan as of the time and date of such reemployment.

2.2 Nature of Payments.

(a) **No Admission of Liability:** The Plan has been established and is maintained by the Employers to protect themselves from certain liabilities as nonsubscribers to the Texas workers' compensation insurance system. Payments made under this Plan by an Employer shall not in any way constitute an admission of liability or responsibility by an Employer for an Injury and any such liability or responsibility is specifically denied.

(b) **No Collateral Source:** Benefit payments under the Plan shall be considered to be made by the Employer of a Participant and shall not be considered payment from a "collateral source" as that term has been defined under any applicable rule, statute, judicial decision, or directive. All benefits paid under this Plan shall be offset against any alleged liability of the Employer, its officers, directors, or agents to a Participant or Participant's Beneficiaries, heirs, or assigns due to an Injury.

2.3 Arbitration of Certain Injury-Related Disputes. The Employer hereby adopts a mandatory company policy requiring that the following claims or disputes must be submitted to final and binding arbitration under this Section 2.3: (A) any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions in an AZTEX Advantage Acknowledgement Form or this Section 2.3; and (B) any legal or equitable claim by or with respect to a Participant for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for assault, battery, negligent hiring/training/supervision/retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Section 2.3). This includes all claims listed above that a Participant has now or in the future against an Employer, its officers, directors, owners, employees, representatives, agents, subsidiaries, affiliates, successors, or assigns. This does not, however, include any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Plan. The determination of whether a claim is covered by this Section shall also be subject to arbitration under this Section. Neither a Participant nor an Employer shall be entitled to a bench or jury trial on any claim covered by this Section. This Section applies to all Participants without regard to whether they have completed and signed an AZTEX Advantage Acknowledgement Form. These provisions also apply to any claims that may be brought by a Participant's spouse, children, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.

(a) **Required Notice of All Claims:** When a party seeks arbitration, such party must give written notice of any claim to the other party within the applicable statute of limitations. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given, the claim shall be void and deemed waived. The party requesting arbitration must send written notice in triplicate to the American Arbitration Association,

Attention: Regional Claims Administrator, at 13455 Noel Road, Two Galleria Tower, Suite 1750, Dallas, Texas, 75240-6620. If an Employee wishes to invoke arbitration, the Employee must also send written notice to AutoZone, Inc., in care of Litigation Manager, P. O. Box 2198 Memphis, TN 38101-9842 (or such other person or address as the Employer may specify). If the Employer wishes to invoke arbitration, the Employer must also give written notice to the Employee at the last address recorded in the Employee's personnel file. The party requesting arbitration must identify and describe the nature of all claims asserted and the facts on which the claims are based. This written notice shall be sent certified or registered mail, return receipt requested.

(b) **Arbitration Procedures:** Any arbitration under this Section will be administered by the American Arbitration Association ("AAA") under its then-current National Rules for the Resolution of Employment Disputes (except to the extent that a different rule is set forth herein) before an arbitrator from the American Arbitration Association. The arbitrator selected by the parties in accordance with those rules shall be an attorney licensed to practice in the State of Texas with experience in personal injury litigation. If the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process. The arbitrator will apply the substantive law (and the laws of remedies) of Texas (other than the Texas General Arbitration Act), or federal law, or both, depending upon the claims asserted. The arbitrator will provide brief findings of fact and conclusions of law. All decisions rendered by an arbitrator under this Section will be kept confidential by all parties, and shall not serve as binding, legal precedent with respect to subsequent claims or disputes under this Section.

(c) **Payment of Fees and Expenses:**

(1) The AAA filing fee will be at least $750. The Employee's share of this cost is $125 and must be paid when he or she submits a request for arbitration (or, if this process is challenged by an Employee, when arbitration is compelled by court order). The Employer will then pay the remainder of the AAA filing fee. The Employer will also pay the arbitrator's entire fee and any other AAA administrative expenses; provided, however, that an Employee may elect to also pay up to one-half of these fees and expenses.

(2) If the arbitrator finds completely in favor of the Employee on all claims, the Employer will reimburse the Employee for his or her share of the filing fee.

(3) If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), the Employee will pay no portion of the AAA or arbitrator fees.

(4) Either party may arrange for, and pay the cost of, a court reporter to provide a stenographic record of the proceedings.

(5) Each party shall also be responsible for their own attorney's fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney's fees to the prevailing party.

(6) Notwithstanding the above provisions, the arbitrator shall assess the AAA filing fee, arbitrator fees and expenses, and attorney's fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless.

(7) If either party pursues a claim covered by this Section by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.

(d) **Interstate Commerce and Venue:** The Employer is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas and providing goods and services to customers from other states) and the Employee's employment involves such commerce. The Federal Arbitration Act shall govern the interpretation, enforcement, and proceedings under the arbitration provisions of this Plan. Unless contrary to applicable law, any lawsuits challenging the validity or enforceability of this Section, seeking to compel arbitration under this Section, seeking to enforce or vacate an arbitration award, or otherwise related to this Section shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

(e) **Binding Effect:** This provision for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each Participant and his/her spouse, children, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns. This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute. This Section applies to all Participants without regard to whether they have completed and signed an AZTEX Advantage Acknowledgement Form. Adequate consideration for this arbitration provision is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employers and Participants. Any actual payment of benefits under this Plan to or with respect to a Participant shall serve as further consideration for and represent the further agreement of such Participant to the provisions of this Section. This arbitration provision shall remain in effect with respect to the Employers and all Participants, without regard to any Participant refusal of benefits under this Plan, return of benefit payments under this Plan to an Employer, ineligibility for or cessation of benefits under this Plan in accordance with its terms, or any voluntary or involuntary termination of a Participant's employment with an Employer. This arbitration provision is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Plan in any way, and is included herein strictly as a matter of convenience in documentation. This Plan and arbitration requirement also in no way changes the

"at will" employment status of any Participant not covered by a collective bargaining agreement.

ARTICLE III

BENEFITS

Participants shall be entitled to receive under this Plan the benefits described in this Article III with respect to any Injury incurred (i) in the Course and Scope of Employment by an Employer, and (ii) during his or her participation in this Plan.

3.1 Wage Replacement Benefits.

(a) Total Disability: From the first full day of an injured Participant's Disability, the Plan shall pay Wage Replacement Benefits equal to 90% of the injured Participant's Pre-Injury Pay.

(b) Partial Disability: From the first full day of an injured Participant's Partial Disability, the Plan shall pay Wage Replacement Benefits equal to 90% of the injured Participant's Pre-Injury Pay, minus the amount of the Participant's earnings from Modified Duty work.

(1) If a Participant with a Partial Disability is released to Modified Duty, but (i) the Company has no Modified Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released the Participant to any other gainful employment, then the Participant shall be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under subsection (1) above.

(2) If a Participant with a Partial Disability has made a good faith effort to comply with the treating Approved Physician's instructions and carry out the Participant's responsibilities in the Modified Duty position, but is either:

(A) again determined by an Approved Physician to be Totally Disabled, or

(B) the Modified Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released the Participant to any other gainful employment;

then the Participant will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under subsection (1) above.

(c) Payment Terms and Other Limitations: Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments

for portions of a week shall be prorated. Only the Participant's normal, scheduled workdays shall be considered in calculating benefits (based upon his or her employment status as of the date of Injury). Wage Replacement Benefits shall be reduced as described in Article VII.

(d) When Wage Replacement Benefits Cease: Wage Replacement Benefits shall continue until the earliest of:

(1) the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not the Participant qualifies as Disabled at all times during such period or receives Wage Replacement Benefits continuously throughout such period. In no event shall this Plan pay benefits for successive periods of Disability resulting from entirely different and unrelated causes, unless such periods of Disability are separated by at least one full day during which the Participant is not Disabled;

(2) the date the Participant is certified by the treating Approved Physician to no longer be Disabled, without regard to whether the Participant returns to regular or Modified Duty on that date;;

(3) the date that the Maximum Benefit Limit is met;

(4) termination of both the Participant's status as a Covered Employee and all other employment of the Participant with an Employer; provided, however, that this paragraph (4) shall not apply if termination of employment is solely due to -

(A) application of a duration limit in the Employer's leave of absence policy, or

(B) elimination of the Participant's employment position;

(5) the date the Participant is placed in jail, is deported or detained by or at the request of any government agency or foreign government, has left the local area for an extended period of time, or is similarly unavailable for work; provided, however, that this paragraph (5) shall operate to cease Wage Replacement Benefits only for such period of time that such Participant is unavailable for work; or

(6) as otherwise provided under Section 4.3.

3.2 Death Benefits. In the event that a Participant dies as the direct and sole result of, and within 365 days of, an Injury, then the Plan shall pay such Participant's Beneficiary a Death Benefit equal to $150,000; provided, however that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Limit. The Death Benefit shall be paid to the Participant's Beneficiary as follows: (i) 20% of the

Death Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the death of the Participant and the determination of the proper Beneficiary; and (ii) the remainder of the Death Benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment. Death Benefits payable under this Plan shall be in addition to Medical Benefits, Wage Replacement Benefits, and Dismemberment Benefits payable to, or with respect to, the Participant; provided, however, that no interest in future Dismemberment Benefits survives after a Participant's death which results in the payment of benefits under this Section 3.2. In addition to the Death Benefits set forth above, the Plan shall reimburse reasonable burial expenses to any person who incurs liability therefor, up to $6,000.

3.3 Dismemberment Benefits. In the event a Participant suffers a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Plan shall pay the Participant the amount set forth in such Schedule, which represents a percentage of $150,000; provided, however, that this benefit amount shall be reduced to the extent necessary to avoid exceeding the Maximum Benefit Limit. The Dismemberment Benefit shall be paid as follows: (i) 20% of the Dismemberment Benefit shall be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (ii) the remainder of the Dismemberment Benefit shall be paid in 35 equal monthly installments (without interest), commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

Loss of:	Benefit Amount:
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

(a) If the Participant suffers more than one Injury described above from any one Accident, related series of Accidents, or Occupational Disease or Cumulative Trauma exposure only one of the applicable Dismemberment Benefits listed above, the largest single amount, will be payable with respect to such Accident or exposure.

(b) Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.

(c) Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint. Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.

(d) The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx.

(e) Dismemberment Benefits shall be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment

Benefits will cease in the event of the death of the Participant which results in the payment of Death Benefits.

3.4 Medical Benefits. Subject to the medical management and other provisions of this Plan, the Plan shall pay Medical Benefits to, or with respect to, a Participant for an Injury in an amount equal to all Covered Charges; provided, however, that Medical Benefits shall cease upon the earliest of:

(a) the expiration of 120 weeks from the date of an Injury;

(b) reaching the Maximum Benefit Limit;

(c) involuntary termination of employment of the Participant with an Employer for Gross Misconduct; or

(d) the Participant not receiving medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or

(e) as otherwise provided under Section 4.3.

ARTICLE IV

ADDITIONAL REQUIREMENTS AND LIMITATIONS ON BENEFITS

4.1 Reporting. The Participant must report every incident or fact that the Participant believes results, or might reasonably be expected to result, in an Injury in accordance with the following requirements:

(a) Notice of Injury: The Participant (or a person acting on his or her behalf) must provide verbal notice immediately after being injured at work to his or her Manager On Duty, no matter how minor the Injury appears to be. For Injury due to an Accident, or for a known exposure to an Occupational Disease, verbal notice must be provided within 24 hours of the time of the Injury. For an actual Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided within 24 hours after being medically diagnosed or within 30 days after the Participant should have known of the Injury, whichever is earlier.

(1) With respect to reporting an Injury due to Occupational Disease or Cumulative Trauma, if an Employer has purchased an insurance policy described in Section 5.2, the purpose of which (in whole or in part) is to indemnify Participants or the Employer for Plan benefits, then the notice of Injury due to Occupational Disease or Cumulative Trauma must in all events be provided not later than 35 months after the end of the policy period.

(2) No benefits will be payable under the Plan if notice is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner. In addition to the foregoing, the Participant must also notify his or her supervisor (verbally or in writing) of expected recovery time immediately after receiving primary medical treatment, and after each succeeding appointment with the treating Approved Physician.

(b) Providing Required Information: An injured Participant (or a person acting on his or her behalf) and such Participant's manager then on duty (or such other person as the Claims Administrator may specify) must complete such Injury report, investigation, and authorization forms, file such written statements, provide such recorded statements (whether sworn or unsworn), and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm suffered by the Participant, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may from time-to-time direct. The written incident report must be provided within 24 hours after the Injury is reported as required under subsection (a) above. No benefits will be payable under the Plan if all information is not provided as required above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a complete and timely manner.

4.2 Medical Management.

(a) Use of Approved Providers: Requirements for the use of Approved Physicians and Approved Facilities are found in the "Covered Charge" definition of this Plan. If necessary, the Claims Administrator will assist a Participant in arranging for appropriate medical treatment from an Approved Physician or Approved Facility. A Participant does not have the right to select and have the Plan pay for his or her choice of a primary care provider or provider of specialty medical care, even if such a provider is an Approved Physician or Approved Facility.

(b) Medical Determinations and Treatment: All determinations relating to the physical condition of a Participant, upon which the continued payment of benefits is based (for example, inability to return to work or results of a prior injury), must be made by an Approved Physician. The Participant must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator may require that the Participant present an authorization and report form to the treating Approved Physician or Emergency Care provider at the time of primary medical treatment. The Employer may also require that the Participant submit to any form of drug and alcohol testing in accordance with the Employer's drug and alcohol testing policies. The Claims Administrator shall have the right to require the Participant to be examined or reexamined by an Approved Physician (including, but not limited to an autopsy, where not prohibited by law) as often as the Claims Administrator determines to be reasonably necessary or appropriate during the pendency of a claim for benefits under the Plan.

(c) Initial Treatment and Denial: Any provision of this Plan to the contrary notwithstanding, an Employer may render First Aid, or the Plan may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment of a Participant, and the Plan can still make a subsequent determination that the Participant has not suffered a covered Injury or otherwise deny any or all further benefits under the provisions of this Plan.

(d) Medical Provider Referrals: If the treating Approved Physician finds it necessary to refer a Participant to another healthcare provider, the treating Approved Physician must notify such Participant and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. It is the Participant's responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral shall be solely the responsibility of the Participant.

(e) No Interference with Patient-Provider Relationship: Although benefits under this Plan are conditioned on a Participant's use of only Approved Physicians and Approved Facilities, a Participant remains entitled to seek any medical care he or she deems appropriate from any provider of his or her choice at his or her expense. However, expenses for such medical care shall not be payable under the Plan and the Participant's use of a non-approved physician or facility may result in a complete denial or termination of Plan benefits. The Employers, Claims Administrator, and Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other healthcare services provided by any Approved Physician, Approved Facility or other designated healthcare service provider. Healthcare providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, or Committee are not liable or responsible for the acts or omissions of any healthcare provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other healthcare providers based on their independent judgment for the provision of health care.

(f) Professional Medical Review and Quality/Efficiency Features: The Claims Administrator shall have the discretion to assign Approved Physicians and other healthcare providers or firms to a Participant's case in order to (i) coordinate and expedite medical treatment of the Participant, in consultation with the treating Approved Physician, (ii) facilitate such case management, quality, and efficiency measures and procedures as the Claims Administrator deems appropriate, based upon particular facts and circumstances, and (iii) review the propriety of any and all treatment, services, and supplies, including charges for such treatment, services, and supplies. Without limiting the generality of the foregoing, the following case management, efficiency, quality control and cost containment features may be utilized under the Plan, at the direction of the Claims Administrator,

to help ensure that health care services are being effectively and efficiently provided:

(1) Fee Schedules: No cost shall be a Covered Charge to the extent that it exceeds the charge specified in any fee schedule approved or adopted by the Claims Administrator. In the event such charge is not listed in such a fee schedule, the charge shall not be considered a Covered Charge to the extent it exceeds the Usual and Customary charge.

(2) Alternative Health Care Facilities: Use of Approved Facilities other than hospitals, including surgicenters, Skilled Nursing Facilities, and Home Health Care Agencies;

(3) Concurrent Review: A review by designated healthcare personnel that utilizes Approved Physician-developed criteria and standards for determining the appropriateness of reimbursement for initial or continued treatment or hospital confinement;

(4) Cost-Saving Techniques: Such techniques include not admitting to hospitals on weekends whenever possible and obtaining second opinions before surgery if deemed advisable by the Approved Physician or the Claims Administrator;

(5) Pre-Admission Evaluation: A review made by healthcare personnel to (i) determine whether each Approved Facility admission is Medically Necessary, and (ii) evaluate the number of days for an inpatient Approved Facility confinement that would be considered reasonably necessary for the care and treatment of the diagnosed Injury;

(6) Pre-Admission Testing: Routine diagnostic, x-ray and laboratory examinations performed within three days of a scheduled Approved Facility confinement (these tests must be performed at the same Approved Facility where such confinement is to occur);

(7) Utilization Review: A review made by designated healthcare personnel to consider, in accordance with established medical criteria, requests from Approved Physicians for medical procedures, tests or other services prior to the provision of such requested services to determine whether they are Medically Necessary, the specific benefit of the services for the Participant, and any alternative means to provide such services;

(8) Nurse Case Managers: The Claims Administrator may assign a nurse case manager or other healthcare professional to monitor services provided or requested on behalf of a Participant, and to otherwise assist the Claims Administrator or the Participant with his or her return to work; and

(9) Referral to Specialty Providers: The Claims Administrator may direct any Participant to an Approved Physician or other healthcare provider who is recognized to be a specialist with the type of condition for which the Participant may need assistance.

(g) Second Medical Opinions. The Plan reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan. If a Participant refuses to be examined by an Approved Physician selected by the Claims Administrator for the second opinion, all benefits under the Plan shall be suspended.

(1) The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan. However, if the Participant is in disagreement with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then the Participant may request a second medical opinion. The Participant must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan. If the Participant provides advance notice to the Claims Administrator, then the Participant shall have the right to a one-time examination at his or her own expense by another physician ("Physician B"). This examination by Physician B shall be solely for the purpose of evaluating the Participant's condition and making a treatment recommendation.

(2) If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. If the Participant refuses to be so examined, all benefits under the Plan may be suspended. The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although the Participant shall have the option of paying up to one-half of such fees and expenses).

(h) Use and Disclosure of Protected Health Information. See Appendix B attached hereto.

4.3 Suspension Or Termination of Benefits. The Claims Administrator may deny a claim for, or suspend or terminate the payment of, Plan benefits otherwise due a Participant if:

(a) the Participant refuses to submit to drug and alcohol testing in accordance with the Employer's drug and alcohol testing policies, or refuses to